Preventing Suicide In Florida

A Strategy Paper

By the Florida Task Force on Suicide Prevention
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►Purpose

The purpose of this strategy paper is to provide policy direction to Florida's state and community leaders in order to decrease the incidence of youth suicide in Florida. The authors comprise a task force brought together under the direction of the Governor of the State of Florida consisting of suicide victims' survivors, suicide prevention support groups, medical experts and government officials. Their intent is to provide programs and initiatives that will lead to progress toward stated goals and objectives ensuring lower suicide rates in general and appreciably lower numbers of youth and elder suicides in particular. The insights and recommendations offered herein are drawn from experts in the field dedicated to preventing the tragedy of suicide. The experts we have consulted or whose work we have drawn from include:

- Parents who have survived the tragic deaths of their own children and are passionately committed to preventing other families from experiencing the devastating effects of these self-destructive acts;
- The Office of the U.S. Surgeon General, whose detailed strategy and related papers on suicide have brought together the best information available nationwide;
- National researchers in this field, that have identified evidence-based prevention and intervention practices.
- Florida's child-serving and elder adults agencies, including the Departments of Health, Education, Children and Families, Elder Affairs and Juvenile Justice, each of whom can play a key role in addressing this serious problem;
- Associations and organizations at local, state, and national level known for their commitment and objectivity in informing the public as to the extent of the problem and in advancing methods to alleviate it.

The factors that contribute to a suicide are complex and diverse; accordingly the efforts to prevent suicide must incorporate multiple approaches. This paper is not offered as a conclusive answer to the tragedy of suicide. Instead, it is meant to be a start -- a statement of the extent of the problem, a summation of the available data, an identification of the information not available but necessary for a solution, a listing of available methods of mitigating suicide risk, and a call for specific actions to alleviate the problem. As such, its prime value is in: (1) formulating a base upon which further knowledge and information can be added as they become available, and (2) as a policy beginning to which can be added increasing numbers of programs, initiatives, and processes as they are developed.

►Background

Recognizing that statistics, trends, and facts are very important in the analysis of any issue, the authors of this paper have reviewed the latest data and research findings on suicide. What the data cannot show, however, is the overwhelming anguish felt by the family, friends, and the entire community when an individual dies from his or her own hand. Whenever a family loses a loved one, the grief is deep and painful, but when the death is by suicide, the hurt can be even more agonizing. Too often the surviving family members are stigmatized, adding to their burden of hurt and intensifying their isolation.

Parents, siblings, friends, and others who knew the deceased often feel that if only they had "done something" the person would still be alive. Parents especially can feel overpowering guilt for not realizing something was wrong in their child's life, or certainly nothing serious enough to end in death. Sadly, sometimes in hindsight it becomes apparent that the person was in distress but no one close knew how to assess the risk of suicide, leaving those who might have helped uninformed of the risk of suicide and what to do about it.

The reality is that not only are concerned individuals devoid of systemic ways to become aware of and respond appropriately to potential suicide, so too are health professionals. The latter face many challenges when caring for those with mental health problems related to high risk behaviors leading to suicidal ideation or actual suicide attempts. Already stressed emergency medical facilities are often overwhelmed by the need to provide emergency care or placement for patients that are considered a threat or harm to themselves or others.

Identification of high-risk patients proves insufficient in and of itself. Without systems in place to follow-through on identification of a potential suicidal person, the worst may follow.

For example, it is not uncommon for a depressed, suicidal 15 year old to wait for hours or even days in an emergency department while efforts are made to find a mental health facility or hospital that has the space or expertise for care. During this time the patient and his or her family become increasingly stressed. Often parents become embarrassed or angry and try to convince the medical staff that their child can be treated as an outpatient. Even when admission for follow-through care does occur, it is often for only one or two days, insufficient time to address the problem.

Florida emergency medical facilities and physicians seeing high volumes of patients displaying risk factors of potential suicide report the following:

- Difficulty in determining the patients insurance or funding status and assigned primary care physician. These problems are exacerbated in emergency department settings after regular business hours.

- Difficulty in determining what mental health facility or plan is contracted with the insurance company, HMO, or payer.

- Delays in high risk patients being accepted for inpatient mental health or psychiatric care for a variety of reasons that included: proof of coverage; facilities having over-extended capacities; facilities not accepting children and/or adolescents; unavailability of medical personnel authorized to make decisions; and demands for

inappropriate medical evaluations and tests at the emergency facility.

- Denial of inpatient mental health or psychiatric treatment if the patient is not actively suicidal despite any assurances that the patient will be adequately treated as an outpatient. Such denials were reported even after severe depression, and/or the patient having a very unstable home situation.

- Lack of mental health professionals willing to treat Medicaid patients (due to low reimbursements rates).

►Facts and figures

In recent years, Florida's suicides continue at a steady rate, showing a variation in the incidence per 100,000 from 14.26 in 1996 to 13.64 in 1998. These are unacceptable numbers that cannot be tied to any causality factors that would explain their failure to go down. Indeed, the ubiquity of suicide throughout the nation is shocking.

- In Florida in 1998, twice as many people died from suicide (2172 deaths) than died by homicide (1083 deaths). Nationwide there are approximately 31,000 suicides a year.

- In 1998, suicide was the second leading cause of deaths for Florida's youth aged 15-19

- For young people 15-24 years old, suicide is currently the 3rd leading cause of death, exceeded only by accidents and homicide.

- Suicide rates for women peak between the ages of 45-64, and do so again after 75.

- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease *combined*.

- Nearly 60% of all suicides are committed with a firearm.

- Not all deaths that are suicides are reported as such. For example, deaths classified as homicides or accidents, where individuals may have intentionally put themselves in harm's way, are not included in suicide rates.

- Suicidal individuals sometimes harm or kill other people before killing themselves.

- Recent studies show that 90% of teenagers who commit suicide have a psychiatric diagnosis, usually some form of depressive disorder, alcohol or substance abuse, or both.

- Medical costs in Florida for completed acts of suicide were estimated at $40 million in 1996; related costs were estimated at $662 million.

- Males commit suicide at a rate four times that of females. However, twice as many females as males attempt suicide.

►Causes of suicide

According to the *1999 Florida Youth Suicide Prevention Study,* (produced by the Florida Mental Health Institute, University of South Florida, for the Department of Children & Families)

Research indicates that youth suicide is inextricably linked to depression and other mental health disorders, substance abuse, violence and access to lethal means, and negative life events. According to the literature, the most commonly identified primary youth risk factors include affective illness such as depression, substance abuse, a prior suicide attempt, antisocial or aggressive behavior, a family history of suicidal behavior, and availability of firearms.

In addition, research has identified precipitant factors in youth suicide. Stressful life events as well as substance use are two. Also, most completed youth suicides were often preceded by a shameful or humiliating experience or the fear of failure or rejection, acute disciplinary crisis, or interpersonal conflict with a romantic partner or parent.

Although psychiatric problems are probably the most significant risk factor for suicide or suicidal behavior, few suicide victims are in treatment at the time of their suicide. One researcher suggests, "proper assessment and treatment of these psychiatric conditions are likely to be the most effective mechanism for the prevention of youthful suicide."

Despite such findings, the number of facilities providing pediatric or adolescent mental health services has declined due to financial constraints, lack of trained staff and a challenging (often unto frustration) work environment. Emergency departments, outpatient clinics and primary care physicians are often unaware of the current mental health resources available in their community and are thereby hampered in their ability to find placement for in or outpatient treatment for their patients. The difficulty involved in determining a patient's financial eligibility for specific mental health programs or facilities is often overwhelming and can delay the provision of care. In turn, the lack of care threatens to increase the probability of suicide.

Suicides, therefore, remain unchecked because of two general shortfalls. The first is a failure to recognize the risk factors and signals that indicate a higher probability of suicidal acts. The second is a diminished ability to get an identified suicide risk to timely, efficient and affordable treatment. Both shortfalls are tragic, but they are not insurmountable. Both can be addressed by better education, access to readily available information, integration of effort across agencies, organizations and facilities, and appropriation direction and application of resources.

►Prevention resources

Although the Task Force recognizes that there is a shortage of necessary suicide prevention resources, the fact remains that there are a number of existing entities that seek to address the problem of suicide.

These include:

Public information and referral:

The Department of Health, Education, Children and Families, Elder Affairs, and Juvenile Justice are able to direct family and friends to community organizations, such as "First Call for Help", to provide information about mental health abuse and substance abuse services in all regions of the state. These "Information and Referral" providers can help a parent, teacher or friend locate professional help for an individual with depression, anxiety, substance abuse or other high-risk condition. While such local referral avenues are helpful, it follows that an integrated statewide referral system would be a logical "next

step". At national level there is a 1-800-Suicide line.

Resources for parents: The Department of Juvenile Justice funds a parent hotline through a contract with the Florida Network of Youth and Family Services. A toll-free number (888) 41-Family, is widely advertised and staffed 24 hours a day, seven days a week by trained staff who offer advice and services to families whose children exhibit troublesome behaviors, such as running away, habitual truancy, or ungovernable behavior.

School-based prevention: The Department of Health, through its county health departments, works intensively with the public schools to provide health education for students, including mental and emotional health, the effects of alcohol and other drugs, and the development of nonviolent conflict resolution skills. Additionally, its School Health Program has assisted the local school districts develop suicide intervention plans and screening protocols.

Public education campaigns: Several of the state child-serving agencies have public education campaigns that address specific issues that put children at risk of self-destructive behaviors. Examples include alcohol and drug abuse prevention, promotion of child health and wellness, and child abuse prevention and reporting. Some of these prevention campaigns can be coordinated or redesigned to reach a broader target audience, as we know that prevention of some problems can help to prevent others. Bottom line, however, is that a specific public awareness effort addressing the prevalence of suicide and what can be done about it is needed.

Literature: There is no dearth of literature on the subject of suicide, much of it well-informed and documented. The National Strategy for Suicide Prevention, produced under the auspices of the Centers for Disease Control and Prevention, is an excellent compendium of goals and objectives that, if met, should lower the incidence of suicide. It also includes an extensive list of references to which the sender can refer for additional information on specific subjects. In addition to scientific studies, strategies, and research papers, various associations, such as the American Foundation of Suicide Prevention, put out newsletters that update their membership on developments and share insights on how to address the problem. Moreover, there are available bibliographies on specific areas of the issue. The Florida Department of Education, for example, through its Clearinghouse Information Center, offers for loan or a supply of books, videos, and other material on adolescent suicide issues.

Medical Organizations: A number of professional medical organizations and associations contribute to the effort to reduce suicide. The American Psychiatric Association, for example, maintains an excellent web site [http://psych.org/public_info/index.cfm] that presents facts on mental illness and lists other available agencies that can offer help and advice, such as the American Association of Suicidology, the National Mental Health Association, and others.

Advocacy Organizations: Born of tragedy and loss and driven by a

commitment to lower the incidence of suicide and suicide attempts, a number of citizens' advocacy groups have come forward from around the country. Having suffered the consequences of a lack of information on the presence of potential risk factors in their own loved ones or, unable to find adequate medical means with which to respond, individuals have banded together to mitigate for others their own difficulties. The Suicide Prevention Advocacy Network, [SPAN USA], Yellow Ribbon Suicide Prevention Plan, American Association of Suicidology [AAS], Suicide Awareness/Voices of Education [SAVE], the Florida Initiative For Suicide Prevention, Inc. [FISP], and the American Foundation of Suicide Prevention [AFSP] are some of the groups formed.

► Goals

Florida is determined to bring down the rates of suicide. The intent of this strategy paper is to do just that by initiating and advancing programs that result in more information available to those who can use it before the act of suicide is attempted and, at the same time, to integrate available resources so that, once identified, potentially suicidal individuals can receive the necessary help in a timely fashion. How we plan to do these two things is discussed below, but it is important for us to set the specific targets up front. Therefore, our stated goals are:

- **To decrease the incidence of suicide in Florida by one third,** (from 13.64 per 100,000 in 1998 to approximately 9.0 per 100,000 in 2005).
- **To decrease the incidence of teen suicide in Florida by one third,** (from 9.52 per 100,000 in 1998 to approximately 6.0 per 100,000 in 2005).
- **To decrease the incidence of elder suicide in Florida by one third,** (from 20.34 per 100,000 in 1998 to approximately 13.0 per 100,000 in 2005).

► Discussion

In a perfect world, we would set as our goals the elimination of all suicides. We do not live in a perfect world, however, and human psychology and interaction being what they are, we can, sadly, expect that there will always be some who -- for whatever reason -- see no alternative but to take their own life. Therefore, no matter how determined and resourceful we may be as a society, we would delude ourselves if we thought we could eliminate suicide once and for all. But just as clearly as we see that we cannot eliminate suicide from the human experience, we can deduce that there is no predetermined reason -- nor collection of reasons -- that dictate that the current high rate of suicide must be accepted. In the past ten years over 300,000 Americans died by their own hand.

In the past decade, the suicide rate among adolescents has declined by 25%, most likely an outcome of better treatment modalities for depression and anxiety. On the other hand, since the 1950s, the number of suicides among15-24 years old has tripled. We have to ask ourselves, why is that so? This is not an infectious disease we are talking about, but a human activity, an act of violence against the very person committing the act. At a time in our history when we are rightly concerned about an HIV/AIDS epidemic that is claiming unacceptably high numbers of American lives, the sad fact is that we

are undergoing a suicide epidemic that is killing more than twice as many.

Such realities are obscured from those most vulnerable to their toll. Suicide receives little publicity and by and large is ignored as an issue by those not yet affected by it. Therein lies the rub. Only when suicide is manifest does the shocking reality get driven home. By then, it may be too late.

Our activities, therefore, must be:

First, to heighten awareness of the potential for suicidal activity before it occurs an;

Second, to offer immediate and appropriate resources to curtail such activity once the propensity for it has been identified.

Of this we can be sure: Whatever chain of events transpired to bring together a deadly mix of societal and human phenomena that resulted in an increase in suicides in the last half of the twentieth century can be resisted by countervailing efforts to reverse the trends. We are not predestined to see ever increasing rates of suicide; nor are we compelled to accept the excessive rates that exist today.

The purpose of a strategy is to mobilize resources toward achievement of specified goals. By its very nature, a strategy is dynamic. It offers a plan that when mobilized will bring to fruition the end state it seeks to achieve. But it understands that the plan must be adjusted along the way to maximize progress toward the desired outcomes. It must learn as it goes, reinforcing the programs and initiatives that work well, and modifying and adapting the others to allow them to work better. This is such a strategy.

► What is to be done

First do no harm, but advance the science: There is no room for error in the business of suicide prevention. Whatever programs are adopted they must not lead to an increased incidence of suicide, the opposite of our intention. The history of suicide prevention instructs us that there is a chance that misguided programs that are too explicit in detailing the circumstances surrounding incidences of suicide can lead disturbed individuals to identification with both the cause and effect. The result could be a suicide that otherwise might not have happened.

Conversely, we cannot allow the fear of unintended consequences to stymie efforts to find more effective means of suicide prevention. While inappropriate or overly broad and indiscriminate models are to be avoided, we can set standards for independent research and evaluation that can lead to more effective modalities to prevent suicide. Not to do so would leave us an unacceptable paradox. To remain fixed only on proven methods and to avoid research into yet unproven areas is likely to negate any possibility of progress toward our goals. If the different experiences of youth today compared to a generation ago has resulted in an alarmingly higher incidence of suicide, we must determine what new approaches we can take to roll the numbers back. Limited responses to evolving epidemics are usually not the best way to head off serious health concerns. The answer, therefore, may lie in careful research by qualified experts subject to peer review, with enough control mechanisms in place to ensure progress is made. That means we must be prepared to commit adequate resources to the development and proof of effective suicide prevention strategies. Risk must be mitigated, but progress must be achieved. This has always been the challenge of medical science. There is no reason to believe

that it cannot be met in the specific field of suicide prevention.

Integrate across agencies and organizations: Suicide is not an isolated issue, a phenomenon so distinct that it holds no relationship to other factors. To a large degree suicide has become the silent epidemic of our times. In varying degrees it is related to health issues, substance abuse, financial insolvency, disappointing inter-social relationships, lack of knowledge, familial difficulties, social mores, and other parameters, any or all of which may be entwined with each other. It makes no sense, therefore, for those committed to alleviating the causes of suicide to compartmentalize their efforts. We have the capacity to make the total effect of our many resources greater than the sum of their parts. Integration is key. Schools can help identify children in danger so that health agencies can provide relief. Substance abuse prevention programs can target high-risk populations so that treatment programs can purchase a new lease on life for the troubled. Advocacy organizations can provide mutual support for families of at risk individuals. Juvenile Justice services can screen troubled youth and the Department of Children and Families can provide services. Across the board, faith-based groups can come to the help of individuals contemplating suicide and families shocked and terrified by their so doing.

Each must know how the other is capable of assisting. Teamwork builds with an active appreciation of skills and capacities of all of the players. Not only should each of us learn what the other can do, we must learn who can do it. Simple steps such as reference lists (i.e., readily available names and phone numbers) can help move a troubled individual to a medical professional in time to get appropriate assistance and then back to a family aided by a suicide support group. Achieving such streamlined effective support need not await the breakthroughs of future technologies or treatment modalities. It is essentially a systems-engineering challenge that can be met by dedicated people who not only are expert in their own fields but who are also aware of the entire spectrum of the problem and familiar with the people and places that can contribute to its solution. That solution, therefore, lies in informational awareness, cross-training, and available communications. More critically, however, the solution lies in the hearts and minds of dedicated individuals who are savvy enough and motivated to reach out to others who can provide assistance. In short, what we need is an integrated team effort there and with the right approach we can get it.

Mount a Public Information Campaign: Knowledge is power, and in the case of suicide prevention, it can be life itself. A public awareness effort on the prevalence of suicide and what can be done about it is key to success. To a large degree, suicide has become the ignored epidemic of our times. It is inconceivable that a phenomenon killing twice as many people per year as either HIV/AIDS or drug abuse is ignored by virtually the entire population that has not been personally affected by it. Where are the champions of suicide prevention -- the public icons, sports figures, media celebrities, and academic leaders who would alert the public of the dangers and what can be done about it? Where are the central coordinating authorities of government that have the capacity to integrate responsive efforts? In a ten year span that equates to the length of the Viet Nam War, five times as many Americans will die by their own

hand as lost their lives in that war. Yet the streets are calm, the airwaves devoid of messages, and the bully pulpits quiet on the subject of suicide.

At 30,000 plus dead a year, suicide has become the proverbial elephant in the living room; so obvious in its enormity that conscious effort has to prevail to avoid its mention. But silence is deadly in this regard. We must overcome the reluctance to address so sensitive a subject; we must take advantage of the grassroots organizations and the requisite public offices prepared to speak out on the subject. With a some effort, we can reach out to Florida's citizens and the American people with a strong, effective, and positive message that at one fell swoop can promise to remove the stigma on families wounded by suicide, heighten awareness to all on the danger signs and appropriate responses, and decrease the death rates borne up by ignorance, fear, and isolation. In an age where there is universal agreement as to the power of marketing, there should be little doubt that we can devise an effective public information campaign that will get us toward our goal of fewer suicide deaths.

Train for Success: The growing body of knowledge on suicide prevention indicates a need for specialty training. It is not enough to be well-meaning; family members, law enforcement officials, teachers, health-care professionals, and potential suicides themselves must have the skill sets to avert suicidal tendencies.

We need to provide training for caregivers and community leaders. Research has shown that suicide is neither random nor inevitable. There are risk factors, warning signs and protective factors that all affect suicide. Training programs should include specific and current information on how to access professional assessment and treatment resources in the local community. The Surgeon General recommends instituting training for all health, mental health, substance abuse and human service professionals (including clergy, teachers, correctional workers, and social workers) concerning suicide risk assessment and recognition, treatment, management, and aftercare interventions. This strategy adds to the recommendation that training should be made available to parents, foster parents, and other adults who provide care or supervision for children and adolescents, (to include youths in colleges and universities), as well as the elderly.

Since the reservoir of proven training programs is limited, there needs to be a programmatic commitment to the development of responsible, well-targeted, innovative training models subjected to carefully constructed and independent research protocols. Early intervention is key and must include teachers and school personnel. The latter are likely to perceive early indicators of depression, self-destructive and/or violent tendencies, and withdrawal from social interactions. At the opposite end of the age spectrum, training for elderly care-givers (as well as family members) would be key.

No team can enter the field of play without training and expect to be victorious. Suicide presents a formidable -- but not insurmountable -- foe; the more we train in specific skills (e.g., recognition of signs of suicide risk, efficacious and timely interventions, emotional and systemic support for potential victims and their families, etc.) the more we can expect the requisite team effort to be effective. We need a training system thought through from start to finish, one that begins with research modalities, advances curricula

and training programs to individuals and organizations throughout the chain of concern and care provision, and provides periodic refresher and update mechanisms.

Limit Access to Expeditious Means of Suicide: Suicide is an act of violence one whose execution is likely to inflict enormous physical pain upon the victims. Born of a psychological calculation clouded by depression, desperation, and confusion, its object is to remove oneself from the perceived cause of affliction. Pain, therefore, is merely a byproduct of the act, and in most instances, in the mind of the potential suicide victim, preferably avoided or at least mitigated. The net result is that the more one calculates that the duration or intensity of pain can be lessened; the more likely he or she will proceed with the act. Accordingly, it is not surprising that the majority of suicides are committed by means of a firearm.

It is axiomatic, therefore, that the more we can restrict access to expeditious means of suicide, the more successful we can be in reducing the act itself. As impulse gives way to contemplation of the stress of the action itself, as well as to its fatal consequences, the less likely will be the propensity to follow through. For youth and young adults, especially the less the immediate access to firearms, particularly when the risk factors are present, the less likely the act of suicide. Moreover, the probability of successful completion of the act goes down markedly when firearms are not used. For example, only 10 per cent of the self-poisoning attempts in 1999 were successful; 90 per cent of the firearm attempts succeeded. For older adults, supervising the dosages of legal but potent drugs could reduce suicide rates, especially when suicidal tendencies are evident.

Lower suicide rates can be realized with a combination of public information and caregiver and familial responses. The simple formula is to not make it easy for those so inclined to kill themselves. While those determined to overcome any fear of pain and any obstacle in their path cannot be forever protected from themselves, we can increase the probability of deterrence by limiting access to expeditious means of self-destruction, thereby -- at the least -- buying time for healing to occur and reason to prevail.

Develop a Responsive Health Care System: We must enhance the ability of the medical community to support. Pediatricians, family practitioners, and physicians in the county health departments should be encouraged to routinely assess the emotional and behavioral health of individuals they see in their practices. Physicians who administer the early and periodic screening, diagnosis and treatment of children and elderly adults covered by Medicaid should be encouraged to use optional screening tools for identifying mental health and substance abuse issues and then refer those individuals for assessment and treatment. Training should be provided for physicians on the warning signs of depression in individuals and other conditions that present a high risk for suicidal behaviors.

We also need to expand mental health and substance abuse assessment and treatment for Florida's adults and children. Scientific research has shown that almost all people who kill themselves have a diagnosable mental or substance abuse disorder and the majority have more than one disorder.

Clear progress has been made in the scientific understanding of suicide and mental and substance abuse disorders, and in developing effective interventions to treat these disorders. In order for treatment to work in preventing suicidal behaviors, however, family members, friends and other caregivers need to know where to go for advice and help. Barriers to accessing treatment -- such as waiting lists and non-availability of treatment resources -- must be eliminated.

We need to challenge and reward schools and communities to protect children from bullying and other forms of harassment and intimidation. A teacher in South Florida starts each school year by listing on the blackboard all the ugly, insulting terms the class can think of that children use against each other. He then erases the board and tells his class that those terms will not be tolerated in his classroom. We need to encourage adults to actively protect children from bullying, harassment and discrimination in the schools and in the broader community. Recognition and incentives should be provided to teachers, coaches, youth ministers, scout leaders and other community "gatekeepers" who exemplify the role that adults should play in protecting children.

Based upon specific feedback from medical professionals in Florida concerned about current deficiencies (see background discussion) among the immediate steps needed are:

- Training of healthcare professionals (EMTs, nurses, physicians), law enforcement and school staff to recognize the early risk signs for suicide.
- Development of community-based systems to identify mental health and other resources.
- Education regarding correct coding of mental health related diagnoses.
- Further study of issues related to funding of psychiatric and mental health care.
- Classification of all inpatient and mental health facilities in the state regarding contact information, ages accepted, insurance plans accepted, etc.
- Development of a "follow-up" system to assure that patients seen in an emergency setting receive counseling and treatment.
- Improved data collection systems, to include evaluation and reporting services.

Broaden Support for Suicide Prevention: Suicide prevention has long been an issue in search of leadership. Ironically, it has the potential to be just the opposite -- an issue so threatening to the general health of the public and so inherently amenable to progress once we organize for success as to naturally draw strong backing and viable leadership to its fore. The agenda listed in the preceding sections should go a long way toward publicizing the issue without undue concern for "suicide contagion" (a sort of copycat phenomenon triggered by sensationalized reporting, "how-to" descriptions, or romanticization of the victim or the act). It also lays out a formula for organizing for success. But we cannot rest there: We need to capitalize on such successes by ensuring long term public and private support for suicide prevention.

Political leadership is key. At national, state, and local levels, elected officials and legislatures have the ability to

mobilize popular support, develop and manage effective policies and programs, and generate resources for the purpose of lowering the suicide rates. We can and should identify such leaders, provide them the information necessary to advance the issue, and simultaneously mobilize support groups to spread roots throughout communities that will allow the effort to take hold and grow.

Professional and community leadership must be integrated. While there are many associations and groups (both formal and informal) focused on suicide prevention as a primary or affiliated effort, they could benefit from umbrella organizations that both focus and link their activities. The outcomes could include a concerted and coordinated public media campaign with local emphasis, integrated crisis response systems, coordinated counseling services, mutually supporting research agendas, and interconnected support groups. Educators, medical experts, counselors, caregivers, law enforcement agents, faith-based institutions, and families need to join together in a series of cascading streams of information and responses that not only identify potential victims, but, at the same time, take them through a crisis period and beyond for long term recovery and health.

The media can also play a key role in broadening support for suicide prevention. The media's ability to inform and persuade is legion. At the very least, they could advance suicide prevention efforts by reporting on suicides with greater compassion and less sensationalism. They certainly would be key in advancing a public information campaign as outlined in this strategy paper.

The question is not how to do all this. Indeed, we must ask why it has not yet been done. The component parts are there; the information, the science, and the methodologies are available. What remains is for us to put together all of the pieces into a coherent whole, advance the knowledge in deliberate and sound research modalities, and put at bay one of the deadliest killers in our land -- suicide.

►Conclusions

"There is an urgency to explicitly build into all prevention strategies the vital supports necessary for positive child and adolescent development." This was the first recommendation of the Florida Youth Suicide Prevention Study, based on the information gathered from community forums, focus groups, research literature, and discussions and testimonies from professional service providers, families and friends of youth that have or attempted to commit suicide. The study further recommended that, "while positive youth development is an essential ingredient to the healthy development of all children and youth, it is critical for those youth who are disproportionately at risk."

In 1985, The co-chair of the National Committee on Youth Suicide Prevention poignantly expressed the dilemma of youth suicide confronting communities across the country:

"When the bright promise of a teenager's life is sacrificed by suicide, we are haunted by an unequaled sense of loss, tragedy and anger. There is no greater pain that a parent, family and community can suffer."

"Parents who have lost a child to suicide express frustration in trying to warn others that suicide knows no geographic, economic or social barriers. It is not limited to "problem kids" and could strike your family tomorrow."

“Yet, we offer our kids little advice about what they should do when a friend talks of suicide. We offer little guidance to parents, fostering the attitude that “it won’t happen to us” in our homes and schools. We go on speculating about the causes and solutions, rather than committing resources needed for research and prevention programs.”

“Those who believe suicide is unstoppable are wrong – tragically wrong. We must look the problem straight in the eye and respond on behalf of those thousands of young people who will otherwise choose death over life. The more rapidly we act, the more lives we will save.”

Compelling words. More compelling, though, is the tragic fact that since 1985 we have lost 3,198 of Florida’s children and youth under the age of 24 to suicide.

The recommendations of the task force as codified in this strategy are only words on paper unless they result in action. Some of the recommendations can be implemented with existing resources; some may require additional resources. All will require political will and broad based cooperation and coordination. The net results, however, promises to be a safer environment for the residents of Florida. That is what they deserve and what we should be able to offer to them.